APPEAL ACKNOWLEDGEMENT LETTER
Late Request

[Date]

[Member's Name]
[Address]
[City, State, Zip]

HWLA Member Identification #: ***[insert number]***
DMH IS #: ***[insert number]***

Dear [Member]:

You asked for an appeal from the Notice of Action dated **[insert NOA date]** about **[describe appeal]**. The appeal was received on **[insert date]**, which is more than sixty (60) days after the date on the Notice of Action.

Your appeal is being denied because you did not ask for it within the appeal time limits.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

If you do not agree with this decision, you have the following appeal rights:

1. You can ask for a State Fair Hearing. You must ask for a State Fair Hearing within **90 days** from the date on this letter.

   To request a State Fair Hearing, call 1 (800) 952-5253. If you have trouble hearing or speaking, you can call TTY/TDD at 1 (800) 952-8349. You may also appeal by writing to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

2. We would like to get a copy of your request for a State Fair Hearing if you file one.

This notice does not affect any other HWLA services.

Please call DMH Patients' Rights at (213) 738-4949, or use TTY/ TDD at (800) 735-2929 if you have any questions.

Sincerely,

_____

(Name of Patents' Rights Advocate)

c: Requesting Provider/Clinic/CAU